

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 31876
4171

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| BIRTH NO. _____ | | REG. DIST. NO. 149 | | PRIMARY REG. DIST. NO. 1002 | | Registrar's No. 4171 | |
| 1. PLACE OF DEATH a. COUNTY JACKSON | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY JACKSON | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY | | c. LENGTH OF STAY (In this place) LIFE | | c. CITY (If outside corporate limits, write RURAL and give township) 4104 Chestnut | | 118 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Menzies Hospital Medical Center | | | | d. STREET ADDRESS (If rural, give location) KANSAS CITY 3018 | | | |
| 3. NAME OF DECEASED (Type or Print) FRANK | | a. (First) H. | | c. (Last) Smith | | 4. DATE OF DEATH (Month) 9 (Day) 20 (Year) 52 | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | | 8. DATE OF BIRTH 3-16-1893 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TAVERN OWNER | | 10b. KIND OF BUSINESS OR INDUSTRY TAVERN | | 9. AGE (In years last birthday) 59 | | 11. BIRTHPLACE (City and State or Foreign Country) K.C. MO. 0 | |
| 13a. FATHER'S NAME SAMUEL SMITH | | 13b. MOTHER'S MAIDEN NAME NORA YOUNG | | 14. NAME OF HUSBAND OR WIFE CLARA M. SMITH | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. 487-38-7807 | | 17. INFORMANT'S SIGNATURE OR NAME MRS. C.M. SMITH | | ADDRESS 4104 CHESTNUT K.C. MO. | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | | | MEDICAL CERTIFICATION | | | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Circulatory Failure | | | | INTERVAL BETWEEN ONSET AND DEATH 2 mos. | | | |
| ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | DUE TO (b) Aortic Stenosis - (Rheumatic) 3 years | | | |
| | | | | DUE TO (c) Cardiac Hypertrophy 2 years | | | |
| II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. Adenoma of Left Adrenal Cortex | | | | 2 years | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 4104 | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from June 20, 1949, to Sept 20, 1952, that I last saw the deceased alive on Sept 20, 1952, and that death occurred at 7:30 a.m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE Graham Asher MD (Degree or title) | | | | 23b. ADDRESS 1220 Prof. 2019 Kansas City 6, Mo. | | 23c. DATE SIGNED 9-21-52 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24b. DATE 9-24-52 | | 24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet | | 24d. LOCATION (City, town, or county) (State) K.C. MO. | |
| DATE REC'D BY LOCAL REG. 9-23-52 | | REGISTRAR'S SIGNATURE Geraldine Holmes | | 25. FUNERAL DIRECTOR'S SIGNATURE MELLODY-McGILLEY-EXLAR | | ADDRESS K.C. MO. | |

(Licensed Embalmers' Statements on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.